UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 18-80165-CR-MIDDLEBROOKS

UNITED STATES OF AMERICA

v.

JUSTIN MORGAN WAYNE,

Defendant.
_____/

FACTUAL PROFFER

Defendant Justin Morgan Wayne, his counsel, and the United States agree that, had this case proceeded to trial, the United States would have proven the following facts beyond a reasonable doubt, and that the following facts are true and correct and are sufficient to support a plea of guilty:

1. At all times relevant to the Information, substance abuse treatment was regulated under state and federal law. Pursuant to Florida's Marchman Act, appropriate substance abuse treatment needed to be "a professionally directed, deliberate, and planned regimen of services and interventions that are designed to reduce or eliminate the misuse of drugs and alcohol and promote a healthy, drug-free lifestyle." Fla. Stat. 397.311(a).

2. At all times relevant to the Information, the Marchman Act made it unlawful for any person or agency to act as a substance abuse service provider unless it was properly licensed. Fla. Stat. § 397.401(1); Fla. Admin. Code § 65D-300.003(1)(a).

3. The Patient Protection and Affordable Care Act of 2010 ("ACA"), Pub. L. 111-148, and other federal laws expanded the availability of private insurance to pay for substance abuse treatment in several ways. First, the ACA allowed parents to maintain health insurance for their children through their own insurance policies until the children reached the age of 26. Second, federal law mandated that substance abuse treatment and other mental health treatment must be covered and reimbursed by insurance policies in the manner and at the same levels as other medical treatment. Third, the ACA required insurance companies to cover individuals regardless of prior existing conditions. Fourth, annual and lifetime caps on coverage were removed. Fifth, the ACA created insurance exchanges that allowed uninsured individuals to apply for and obtain coverage from private insurers. The combination of these provisions created insurance coverage for patients and substance abuse treatment that had previously been excluded from coverage. Federal health care benefits programs were likewise expanded.

4. These federal laws created access to coverage through a number of avenues, including health plans sponsored by private employers, federal health care benefits programs, and health plans offered directly by private insurance companies. Private insurance companies administer health plans sponsored by private employers and governmental employers. Health plans sponsored by private employers are governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*, while those sponsored by governmental employers and certain others are exempted from ERISA's jurisdiction.

5. The Federal Employees Health Benefits Program ("FEHBP") provided medical benefits, items and services to federal employees and their dependents, including substance abuse services. The United States Office of Personnel Management ("OPM") managed the FEHBP and contracted with various insurance companies to offer these benefits. FEHBP reimbursed those insurance companies out of government funds for the money the insurance companies paid out for medical benefits, items and services for federal employees and their dependents. BlueCross/BlueShield ("BCBS") was one of the various insurance companies contracted by the Office of Personnel Management to offer medical benefits, items and services to federal employees under the FEHBP.

6. The National Railroad Passenger Corporation, doing business as Amtrak ("Amtrak"), was a private, for profit, Government corporation, that operated a nationwide system of passenger rail transportation. As part of its employee benefits package, Amtrak established employee health and welfare benefit plans to provide healthcare to their employees, including their spouses, domestic partners, and dependent children (collectively, "dependents").

7. Both ERISA and non-ERISA health benefit plans, including ACA plans, were offered or administered by private insurance companies, including Blue Cross/Blue Shield, Aetna, Cigna Behavioral Health, Cigna Health & Life Insurance Company, United Behavioral Health, and United Health Group.

8. All of these health benefit plans were "health care benefit programs," as defined in Title 18, United States Code, Section 24(b), that is, "public or private plans or contracts, affecting commerce, under which any medical benefit, item or service is provided to any individual."

9. Regardless of the type of plan held by a patient, the amount of coverage and terms and conditions of billing and payment were governed by the terms of the individual's insurance documents, and the insurance company administering the plan had the authority, responsibility, and discretion to make coverage determinations and to process and make payments on claims.

10. Chapter 817 of the Florida Statutes, known as the "Florida Patient Brokering Act," made it a felony for any person, health care provider, or health care facility, including any licensed substance abuse service provider, to: "(a) Offer or pay any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral of patients or patronage to or from a health care provider or health care facility; (b) Solicit or receive any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for referring patients or patronage to or from a health care provider or health care facility; (c) Solicit

or receive any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for the acceptance or acknowledgement of treatment from a health care provider or health care facility; or (d) Aid, abet, advise, or otherwise participate in the conduct prohibited under paragraph (a), paragraph (b), or paragraph (c)." Fla. Stat. § 817.505.

11. Florida law also stated that it "shall constitute a material omission and insurance fraud . . . for any service provider, other than a hospital, to engage in a general business practice of billing amounts as its usual and customary charge, if such provider has agreed with the insured or intends to waive deductibles or copayments, or does not for any other reason intend to collect the total amount of such charge." Fla. Stat. § 817.234(7)(a).

12. Under state and federal law, health benefit plans were only responsible for claims for services that: (a) were "medically necessary," (b) were actually rendered; (c) were provided by a properly licensed service provider, and (d) complied with the terms of the health care plan, including the obligation to pay co-insurance and deductibles.

13. Bodily fluid testing could be used to detect recent drug or alcohol use by a client by conducting various tests on a client's urine, blood, and saliva. Urine Analysis or urinalysis ("UA") testing complexity ranged from screening tests – also known as point of care ("POC") testing – which provided instant results, to confirmatory testing, which was sent to a laboratory, for more complex analysis. Laboratories could also conduct complex analysis on blood and saliva samples.

14. Like other medical tests, bodily fluid testing could be billed to insurance and reimbursed pursuant to the terms of the insurance policy. Insurance companies were only responsible for claims for testing that were "medically necessary," actually performed, prescribed, and conducted by a properly licensed service provider, and conducted and billed in compliance with the terms of the health care plan, including the obligation to pay co-insurance.

15. Defendant Justin [redacted] Wayne ("Wayne") has been a managing member of Smart Lab LLC ("Smart") since its inception in 2014. Wayne functioned as the Chief Operating Officer ("COO") of Smart and handled many of the day-to-day activities for the business.

16. Smart is located at 10385 Ironwood Road, Suite 130, Palm Beach Gardens, Florida, in Palm Beach County, in the Southern District of Florida. Smart offers bodily fluid testing services including confirmatory urinalysis testing. Prior to becoming the COO for Smart, Wayne had no training or experience in urinalysis testing, the clinical laboratory business, or any aspect of substance abuse treatment.

17. Reflections Treatment Center ("Reflections") was located at 5100 Coconut Creek Parkway, Margate, Florida, in Broward County, in the Southern District of Florida. Reflections purported to operate as a licensed "substance abuse service provider" or "treatment center" that is, it purportedly offered clinical treatment services for persons suffering from alcohol and drug addiction. Laura Chatman was the nominee owner of Reflections, although Kenneth Chatman was the true owner and made all financial decisions. Due to Kenneth Chatman's felony conviction, his ownership interest was not disclosed to the State of Florida and Reflections was not properly licensed.

18. On October 19, 2015, Reflections started using Smart to perform urine confirmatory drug testing after Kenneth Chatman was paid a bribe to begin using Smart's services and was promised kickbacks in exchange for referring all of Reflections' urinalysis testing to Smart. To facilitate these kickbacks, Smart paid "sales representatives" a "commission" for each urine sample that Reflections and other treatment facilities referred to the lab for testing. Smart paid illegal kickbacks directly or indirectly to owners or employees of treatment facilities, some of which were disguised as sales commissions. Smart billed private insurance companies as much as $6,200 for testing a single urine specimen and did not disclose to the insurers that the tests were solicited through the payments of bribes and kickbacks.

19. To maximize the kickbacks, Smart prepared "standing orders" and recommended that Reflections and other entities run every available urinalysis test three times per week. Reflections used medical directors who were willing to sign these standing orders even though the tests were not medically necessary and were not used to direct the patients' medical treatment. Smart submitted claims to numerous health benefit plans for the unnecessary and excessive urinalysis testing. Smart also was aware that many of the urine samples from Reflections and other entities were not legitimate, that is, the testing revealed that: (a) samples did not come from the stated patients, (b) patients were actively using illegal drugs; and (c) patients who had not been using drugs when they started at Reflections had begun using drugs while allegedly in treatment. Despite knowing this, Smart submitted these fraudulent claims to the health benefit plans and received proceeds in interstate commerce that were deposited into Smart's bank account at Wells Fargo Bank.

20. Smart entered into an agreement that 50% of the insurance reimbursements would be paid to the "sales representatives" for the treatment centers that sent their urine sample for testing. Although the payments were classified as commissions, in reality they were kickbacks for the referral of excessive, medically unnecessary, fraudulent, and duplicative confirmatory testing.

21. From 2015 through 2017, Lanny Fried, with the concurrence of Wayne and others at Smart, recruited several individuals to act as "sales representatives" for Smart. These individuals signed employment agreements with Smart that made it appear that they were employees of Smart. In truth and in fact, at Lanny Fried's and others' direction, the majority of the wages and commissions Smart paid to these individuals was simply passed directly or indirectly to owners or employees of treatment facilities.

22. The insurance billings generated from the urine samples sent to Smart from Reflections were a substantial portion of Smart's revenues and resulted in substantial increases in distributions made to Wayne and the other officers of Smart.

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23. From on or about March 10, 2016 through on or about November 29, 2016, Smart received more than $2.8 million in payments from insurance companies for the Reflections samples. Smart failed to collect millions of dollars in co-pays, deductibles, and co-insurance, and failed to disclose to the insurance companies that it was not collecting those co-pays, deductibles, and co-insurance as required by the terms of the insurance policies.

BENJAMIN G. GREENBERG
UNITED STATES ATTORNEY

Date: 8/29/2018

By: _____
A. MARIE VILLAFAÑA
ASSISTANT UNITED STATES ATTORNEY

Date: 8/30/18

By: _____
RICHARD G. LUBIN, ESQ.
ATTORNEY FOR DEFENDANT

Date: 8/30/18

By: _____
JUSTIN MORGAN WAYNE
DEFENDANT